DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 5 — 0 7

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 20, 1995

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1995 $193,008,108
b. FFY 1996 $514,688,288

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages 21 thru 27 and
Appendix A Pages 1, 2, and 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages 21 thru 27 and
Appendix A Pages 1,2, and 3

10. SUBJECT OF AMENDMENT: Hospital services reimbrusment plan changes implemented during the January - March 1995 quarter. Pland change to the Federal Reimbursement Allowance (FRA) payment methodology

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
3/30/95

16. RETURN TO:
Department of Social Services
Division of Medical Services
615 Howerton Court
P O Box 6500
Jefferson City, Missouri 65102-6500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/31/95

18. DATE APPROVED:
AUG 02 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
2/20/95

20. SIGNATURE OF REGIONAL OFFICIAL:
Nanette Foster Reilly

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE: Acting
ARA forMedicaid & State Operations

23. REMARKS:

cc:
Stangler
Checkett
Taffe

SPA CONTROL
Date Submitted 03/30/95
Date Received 03/31/95

FORM HCFA-179 (07-92)

Instructions on Back

XIX. Medicaid/Medicare Contractual Payment (MMCP). A Medicaid/ Medicare Contractual Payment shall be provided to hospitals that have a current Title XIX (Medicaid) provider agreement with the Department of Social Services, except first tier 10% Add-on disproportionate share hospitals.

A. Definitions. As used in this subsection:

1. Base Cost Report -- desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during calendar year 1992. (For example, a provider has a cost report for the nine (9) months ending 9/30/91 and a cost report for the three months ending 12/31/91 the second cost report is the base cost report). If a hospital's "Base Cost Report" is less than or greater than a 12 month period, the date shall be adjusted, based on the number of months reflected in the "Base Cost Report" to a 12-month period.

2. Medicaid Contractual Adjustment -- Medicaid contractual allowance reported on the base cost report adjusted for hospital specific cost to charge ratio.

3. Medicaid/Medicare Payment Cap -- Medicaid Contractual Adjustment added to Medicare Contractual Adjustment divided by total inpatient hospital days from the base cost report for each hospital. This yields a per day cost of the Medicaid and Medicare contractual adjustment. The cost per day for each hospital is ranked from lowest to highest cost. The Medicaid/Medicare Payment Cap is established at the twenty-eighth percentile which is $74.13 for the remainder of SFY 95 (February 20, 1995 through June 30, 1995; and

4. Medicare Contractual Adjustment -- Medicare contractual allowance reported on the base cost report adjusted for hospital specific cost to charge ratio and multiplied by fifteen and one tenth percent (15.1%).

B. The Medicaid/Medicare Contractual Payment (MMCP) for each qualifying hospital for the remainder of SFY 95 shall be nine twenty-fourths of the lower of --

1. Medicaid Contractual Adjustment added to the Medicare Contractual Adjustment; or

2. Medicare/Medicaid Payment Cap multiplied by total inpatient hospital days from the 1992 cost report.

C. MMCP Incentive Payment. An incentive payment shall be paid to hospitals with a MMCP cost per day which is at or below the twenty-eighth percentile. The incentive payment shall be determined by multiplying the hospitals MMCP by an MMCP incentive factor. The total MMCP and MMCP incentive shall not exceed the twenty-eighth percentile which is $74.13.

1. The MMCP incentive factor shall be 50% for hospitals at or below the fifth percentile. The fifth percentile MMCP cost per day is $47.80.

2. The MMCP incentive factor shall be 35% for hospitals at or below the tenth percentile. The tenth percentile MMCP cost per day is $56.68.

3. The MMCP incentive factor shall be 20% for hospitals at or below the fifteenth percentile. The fifteenth percentile MMCP cost per day is $60.23.

4. The MMCP incentive factor shall be 5% for hospitals at or below the twenty-eighth percentile. The twenty-eighth percentile MMCP cost per day is $74.13.

D. If a hospital does not have a "Base Cost Report" the information to calculate the Medicaid/Medicare Contractual Payment shall be estimated using the following criteria:

1. Hospitals entitled to a Medicaid/Medicare Contractual Payment shall be ranked from least to greatest number of inpatient hospital beds divided into quartiles;

2. Each factor in the Medicaid/Medicare Contractual Payment calculation, including the MMCP Incentive Payment, shall then be individually summed and divided by the total beds in the quartile to yield an average per bed; and

3. Finally, the total number of inpatient hospital beds for the hospital without the base cost report shall be multiplied by the average per bed to determine each factor.

E. Payments will be allocated and paid over the remainder of State Fiscal Year 95 from February 20, 1995 through June 30, 1995.

F. Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph V.D.2.

XX. Effective October 1, 1992, each general plan hospital shall receive a Medicaid per diem rate, effective for admissions on or after September 30, 1992 through September 17, 1993, based on its general plan (GP) rate compiled in accordance with Subsection XX.A. Each disproportionate share hospital shall receive a rate compiled in accordance with Subsection XX.B.

A. The general plan rate shall be the lower of the most current Title XVIII Medicare rate or the general plan per diem determined from the third prior year desk reviewed cost report in accordance with the following formula:

$$\text{GP Per Diem} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC - The Operating Component is the hospital's Total Allowable Cost (TAC) less CMC.

2. CMC - The Capital and Medical Education component of the hospital's TAC.

3. MPD - Medicaid Inpatient Days.

4. MPDC - MPD as defined previously with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.

5. TI - Trend Indices. The Trend Indices are applied to the operating component of the per diem rate. The trend indices for the third prior fiscal year will be used to adjust the Operating Component to a common fiscal year of June 30.

6. The general plan per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the third prior year desk reviewed cost report and adjusted by the Trend Indices.

B. Disproportionate Share (DS) Rate. The Disproportionate Share rate in effect September 30, 1992 shall be adjusted by the state fiscal year 1993 trend index which shall be applied one-half to the individual hospital operating component and one-half based on the statewide average per diem rate as of June 30, 1992.

C. Trend Indices. Trend indices are determined based on the four quarter average DRI Index for PPS - Type Hospital Market Basket as published in "Health Care Costs" by DRI/McGraw-Hill. Per diem rates shall not be adjusted by a TI for State Fiscal Year 95.

1. The Trend Indices are:

   A. State fiscal year 1990 - 5.30%
   B. State fiscal year 1991 - 5.825%
   C. State fiscal year 1992 - 5.33%
   D. State fiscal year 1993 - 4.68%
   E. State fiscal year 1994 - 4.6%; and
   F. State fiscal year 1995-0%

2. The trend indices for SFY-90 through SFY-92 are applied as a full percentage to the operating component (OC) of the per diem rate. The trend indices for state fiscal year SFY-93 through SFY-95 are applied one-half to the individual hospital operating component and one-half time the statewide average weighted per diem rate as of June 30.

D. Effective September 18, 1993, the General Plan (GP) or Disproportionate Share rate in effect September 17, 1993, shall be adjusted by the state fiscal year 1994 trend index of 4.6%, which shall be applied one-half to the individual hospital operating component and one-half based on the statewide average per diem rate as of June 30, 1993.

XXI. Sole Community Provider Incentive. An incentive payment will be made to sole community hospitals based upon each hospitals operating margin for 1992. The incentive for each qualifying hospital shall be allocated and paid over the remainder of SFY 95 from February 20, 1995 through June 30, 1995. The incentive to be allocated over the remainder of SFY 95 shall be nine twenty-fourths of the annual incentive.

A. Hospitals with an operating margin less than 1% will receive an incentive payment of $100,000.

B. Hospitals with an operating margin greater than 1% but less than or equal to 2.5% will receive an incentive payment of $50,000.

C. All other sole community hospitals will receive an incentive payments of $25,000.

D. Operating margin -- The operating margin reflects the proportion of operating revenue (after allowances) retained as income, and is a measure of a hospital's profitability from patient care services and other hospital operations, and is calculated as follows:

$$\frac{\text{Income from Operations}}{\text{Total Operating Revenue}} \times 100$$

E. Sole community hospital-For the purpose of this section only, a sole community hospital is a hospital, other than a first tier 10% Add-on DSH, which met one (1) of the following definitions during the hospital's 1992 fiscal year:

1. Medicare definition-The hospital was designated a sole community hospital in accordance with the applicable Medicare regulation; or

2. Medicaid definition-The hospital was the only Medicaid enrolled hospital in the community. However, a hospital qualifying

E. Sole community hospital-For the purpose of this section only, a sole community hospital is a hospital, other than a first tier 10% Add-on DSH, which met one (1) of the following definitions during the hospital's 1992 fiscal year:

1. Medicare definition-The hospital was designated a sole community hospital in accordance with the applicable Medicare regulation; or

2. Medicaid definition-The hospital was the only Medicaid enrolled hospital in the community. However, a hospital qualifying under this definition only will receive a maximum incentive payment of twenty-five thousand dollars ($25,000) regardless of its operating margin.

XXII. Trauma Center Incentive. A trauma incentive of $10,000,000 for SFY 94 will be allocated to hospitals, except first tier 10% Add-on DSH, based on trauma level, MMCP ranking and trauma days of care for 1992. The trauma center incentive shall be allocated and paid over the remainder of SFY 95 from February 20, 1995 through June 30, 1995. The annual incentive for the remainder of SFY 95 shall be nine twenty-fourths of the annual incentive.

A. Eligible trauma hospitals are ranked by MMCP and divided into quintiles from low (1) to high (5). Each hospitals trauma days are multiplied by a weighted factor from the trauma center grid. The product for each hospital is divided by the sum of the product for all trauma hospitals and divided by the sum of the product for all trauma hospitals and multiplied by the trauma center incentive to determine the payment to each hospital.

B. Trauma Center Grid:

MMCP	Trauma Level		
Rank	I	II	III
1	100	80	50
2	80	64	40
3	60	48	30
4	40	32	20
5	20	16	10

XXIII. Incentive Payment for the remainder of SFY 95-Incentive Payments for FFY 94-Incentive payments shall be granted to hospitals that have a current Title XIX (Medicaid) provider agreement with the Department of Social Services, except first tier 10% Add-on DSH.

A. Obstetric Service Incentive. Hospitals which rank in the top twenty (20), for calendar year 1992, in the number of Missouri Medicaid births delivered at that hospital compared to Missouri Medicaid birth delivered at all hospitals, or disproportionate share hospitals, shall receive an annual incentive payment of two hundred dollars ($200) per Medicaid birth for calendar year 1992 as determined per Medicaid and live birth records by the Department of Health. For the remainder of SFY 1995, the annual incentive shall be allocated and paid over the Medicaid payrolls from February 20, 1995 to December 31, 1995. The total incentive for the remainder of SFY 95 shall be nine twenty-fourths of the annual incentive.

B. Children's Hospital Incentive. Children's hospitals shall receive an annual incentive adjustment equal to thirty percent (30%) of their Medicare/Medicaid contractual payment after imposition of the Medicare/Medicaid cap but not including the MMCP or other incentive payment. For the remainder of SFY 1995, the annual incentive shall be allocated and paid over the remaining Medicaid payrolls from February 20, 1995 through June 30, 1995. The total incentive for the remainder of SFY 95 shall be nine twenty-fourths of the annual incentive.

C. Primary Care Incentive.

1. A Primary Care Incentive described in this section shall be paid to each hospital which has, or provides assurance that it will have, one or more clinic locations qualifying as a Hospital-Sponsored Primary Care Clinic (HSPCC) for at least five (5) months of Federal Fiscal Year 1994. The annual Primary Care Incentive payment shall be equal to $57,500 plus 1.5% of the sponsoring hospital's MMCP.

2. Following approval of the Hospital-Sponsored Primary Care Clinic Application by the Division of Medical Services, the Primary Care Incentive payment shall be allocated equally to the remaining Medicaid payrolls of State Fiscal Year 1995 (SFY 95). The total incentive for the remainder of SFY 95 shall be nine twenty-fourths of the annual incentive.

3. If the sponsoring hospital fails to maintain at least one HSPCC location for at least five (5) months of Federal Fiscal Year 1994, the Primary Care Incentive payments shall be recouped from the sponsoring hospital in full.

XXIV MMCP and incentive payments for Federal Fiscal Year (FFY) 1995

A. Sections 19 through 23 describe FFY 94 payments for MMCP, MMCP Incentive, Sole Community Provider Incentive, Trauma Center Incentive, Obstetric Service Incentive, Children's Hospital Incentive, and Primary Care Incentive payments which are paid to providers on a prorated basis for FFY 94.

B. MMCP and Incentive payments defined in subsection (24) (A) shall continue at the same prorated level through February 19, 1995.

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Missouri TN - 95-07

REIMBURSEMENT TYPE: Inpatient hospital X

PROPOSED EFFECTIVE DATE: February 20, 1995

A. State Assurances and Findings. The State assures that is has made the following findings:

1. 447.253 (b) (1) (i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. _____

2. With respect to inpatient hospital services - -

   a. 447.253 (b) (1) (ii) (A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. _____

   b. 447.253 (b) (1) (ii) (B) - If a state elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861 (v) (1) (G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act. _____

   If the answer is "not applicable," please indicate:

   _____

State Plan TN# 95-07 Effective Date 2/20/95

Supersedes TN# _____ Approval Date AUG 02 2001

c. 447.253 (b) (1) (ii) (C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. _____

4. 447.253 (b) (2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272 (a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. _____

b. 447.272 (b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) - - when considered separately - - will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. _____

If there are no State-operated facilities, please indicate "not applicable:"

_____

c. 447.272 (c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42CFR 447.296 through 447.299.

d. Section 1923 (g) _ DSH payments to individual providers will not exceed the hospital-specific DSH limits in section 1923(g) of the Act. _____

B. State Assurances. The State makes the following additional assurances:

1. For hospitals - -

a. 447.253 (c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital -indebtedness, return on equity)if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

App AUG 02 2001

3. 447.253 (e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

4. 447.253 (f) - The State requires the filing of uniform cost reports by each participating provider.

5. 447.253 (g) - The State provides for periodic audits of the financial and statistical records of participating providers.

6. 447.253 (h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: February 18, 1995
If no date is shown, please explain:

7. 447.253 (i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved State plan.

C. Related Information

1. 447.255 (a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Hospital

For hospitals: The Missouri Hospital Plan includes DSH payments in the estimated average rates. However, the DSH payments included in the estimated average rates do not represent the total DSH payments made to hospitals under the Missouri Medicaid Plan.

Estimated average proposed payment rate as a result of this amendment:
$635.75

Average payment rate in effect for the immediately preceding rate period:
$635.75

Amount of change: $0.00 Percent of change: 0.0%

2. 447.255 (b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:
This amendment will not effect the availability of short-term or long-term services.

(b) The type of care furnished: This amendment will not effect hospital services furnished to Medicaid eligibles.

(c) The extent of provider participation: This amendment will assure recipients have reasonable access taking into account geographic location and reasonable travel time to inpatient hospital services.

(d) For hospitals - - the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:
It is estimated that disproportionate share hospitals will receive 100% of its Medicaid cost for low income patients with special needs.